



California's Health

Vol. 12, No. 12 • Published twice monthly • December 15, 1954

RECENT TRENDS IN TUBERCULOSIS CONTROL*

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This year marks the fiftieth anniversary of the great antituberculosis movement in the United States. This movement was started by the National Association for the Study and Prevention of Tuberculosis, now called the National Tuberculosis Association.

Great changes have occurred in the tuberculosis picture in this Country since the days when tuberculosis was known as the Great White Plague and was the first cause of death. The work of one of our greatest voluntary health agencies has been persistent and ever present in furthering these changes. We recall that the first public health nurse was a tuberculosis control nurse, and that the tuberculosis organizations have sponsored and helped maintain official health departments in all parts of the Country, and have even organized some. This significant role is being continued, as evidenced, for example, by the great support the San Francisco Tuberculosis and Health Association gave to the recent bond issues concerned with public health. I am sure we are gratified to see the program of tuberculosis associations projecting into broader fields of public health.

Current Status of Tuberculosis Control

The continued fall in the death rate of tuberculosis has been one of the remarkable happenings of our times. All of the reasons for this continued fall are not clear—probably are complex. The fall in California from 1920 onward has been at a rate of 5 to 10

percent annually, but since 1946 the rate has increased to about 25 percent a year. Action of the new drugs, linked with other recent advances in therapy, has proved highly effective in lowering the death rate. The all-time low death rate in California of 11.4 per 100,000 was achieved in 1953.

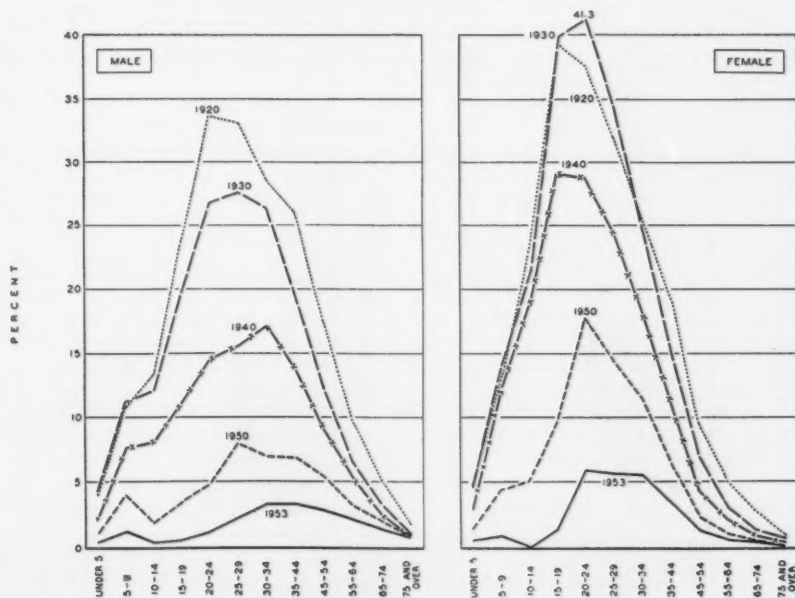
At the same time, the age distribution of deaths due to tuberculosis has

changed. In the adolescent age group, 15-19, tuberculosis in 1920 caused about 33 percent of male deaths and 39 percent of female deaths. In 1953 tuberculosis was the cause of only 1 percent of male deaths and 2 percent of female deaths in the adolescent group. (Figure 1.)

In recent years the case rates show that the incidence of tuberculosis in

FIGURE 1

PERCENT OF DEATHS DUE TO TUBERCULOSIS (ALL FORMS) BY AGE AND SEX
CALIFORNIA, DECENNIAL YEARS 1920 - 1950 AND 1953
BY PLACE OF OCCURRENCE 1920, 1930 AND 1940
BY PLACE OF RESIDENCE 1950 AND 1953



SOURCE: U. S. PUBLIC HEALTH SERVICE, TUBERCULOSIS IN THE UNITED STATES, VOLUME 2
STATE OF CALIFORNIA, DEPARTMENT OF PUBLIC HEALTH, DEATH RECORDS

* Presented at Kickoff Luncheon for Seal Sale, San Francisco Tuberculosis and Health Association, November 22, 1954.

females is still high in early womanhood, but declines after 35, whereas in males the case rate continues upward after 35. (Figure 2.)

The state-wide reporting of new cases has declined much more gradually than the mortality rate. In fact, there were 192 more new cases reported in 1953 than in 1952 in California, but when weighed against the increase in population, the case rate per 100,000 actually declined. The 1953 rate was 69.4 cases per 100,000. This was only a 2 percent decrease from 1952. And, there has been a total decrease of only 19.5 percent in the past five years.

So, despite the remarkable reduction in death rate, the problem of tuberculosis is still with us, and it behooves us to improve our case-finding techniques. Case finding becomes even more important as newer treatments allow us to deal with cases more effectively. As cases become fewer and fewer, each one becomes relatively more significant in the spread of this disease.

Areas of High Incidence

It becomes increasingly important to seek cases of tuberculosis in areas where they are most likely to be found. For instance, in San Francisco, in 1952, 60 percent of the cases came from only three census tracts in the city. Plans can be made to place the most intensive case finding efforts in these special areas.

Tuberculin Testing

Another concept of case finding now emerging is based on tuberculin testing. As tuberculosis decreases it becomes possible to measure the tuberculinization of a community and use this as an index of tuberculosis prevalence. This method has been used in Minnesota where they have found counties with no cases of tuberculosis for several years, and in other counties tuberculin testing in the upper grades of high schools has revealed a small percentage of positive reactions. In our own State, the City of Alameda has revealed an over-all positive reaction of 5 percent among upper high school students. In the future, it may be wise to confine our

case-finding activities to those communities with high tuberculin rates.

In large cities, where there is a great admixture of population, tuberculin testing may not be effective. For such cities, concentrated effort may best be directed to the census tracts of known high prevalence, the jails, the hospitals, the clinics, and physicians' offices. In Los Angeles, the tuberculosis association set up a program in the county hospital which finds about one-tenth of the morbidity of the State. A continuous program has also been set up in the county jail which is also an effective case-finding effort.

Selective case-finding is the magic word of the moment. Your association should be commended for the long-time support of the case-finding units located at the San Francisco Hospital, at the City Health Department, as well as at other local centers.

Hospitalization and Treatment

As you are aware, great changes are taking place in the treatment of tuberculosis. The state tuberculosis subsidy program was set in operation in 1914. It offered counties a subsidy of \$3 a week for every tuberculous patient they housed and treated according to adequate standards of the moment. The counties have accepted this responsibility and now maintain 7,206 beds for tuberculosis patients.

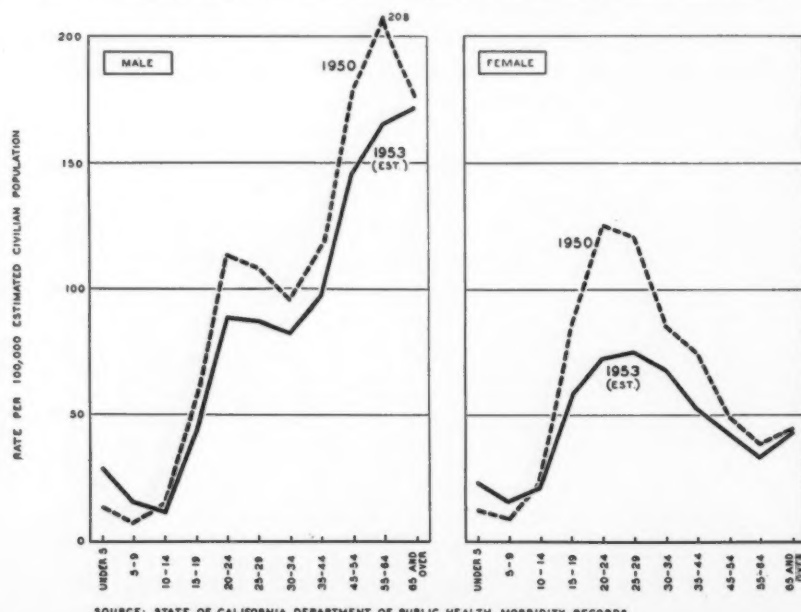
In recent years this subsidy has been increased to meet rising costs incident to general inflation and increased costs of the more advanced medical and surgical treatment of tuberculosis. It now amounts to \$2.95 per patient day, which is still only approximately one-third the total cost of hospital care.

It is interesting to note that there was a 10 percent reduction in bed use in 1952 over the previous year, with a continued reduction in 1953, and again in the current year. Even those institutions that in the past have had large waiting lists have managed to clear their lists, and it is now common to find many institutions with vacant beds. This is largely the result of drug therapy and the increased use of surgery.

As the need for tuberculosis hospital beds decreases, new ways of utilizing these facilities should be explored. With the tremendous need for facilities for care and rehabilitation

FIGURE 2

CIVILIAN CASE RATES FROM TUBERCULOSIS (ALL FORMS) BY AGE AND SEX
CALIFORNIA 1950 AND 1953 (BY PLACE OF RESIDENCE, EXCLUSIVE OF STATE INSTITUTIONS)



of the chronically ill, it is more economical to use these existing facilities than build new ones. Associations such as yours have a responsibility in pointing out such opportunities.

The tuberculosis institution, all authorities agree, is still the place of choice to begin treatment of the tuberculous patient. This not only affords isolation during the infectious stages, but also allows opportunities for patient education. This education is essential because the patient must follow a long regime to prevent future breakdowns of his disease. New drugs have shortened the infectious period, so that it is now possible to discharge the patient earlier and continue treatment at home or in clinics. Present opinion is that drugs should be continued for six months to a year or more after the patient has reached a period of stability of his disease. This creates a new problem for local health departments, because in many instances it is the health department in the home community that must provide and supervise drug treatment of these patients.

Adequate support for the health department in assuming new and augmented responsibility for the home care of the tuberculous patient must be assured. Frequently, the need for additional nurses for home visiting, social workers, and possibly housekeepers must be considered.

Patient Services—Public Health Education

One of the most important contributions of tuberculosis associations has been the provision of patient services. One extremely valuable patient service is the provision of proper health education facilities to tuberculosis institutions that are not able to provide their own. In this way patients can be properly and carefully helped to adjust to their disease, and to many of the problems that so often accompany tuberculosis.

In Chicago, a follow-up study of 1,000 patients has been recently completed. They had been rendered non-infectious by shortened institutional care followed by drug treatment in clinics. During the period of institutional care, patient education was emphasized. In one year there was a relapse rate of only 1 percent. In a similar group that had no institutional care or education, but were given treatment in their homes or in

clinics, it was found that these patients were noncooperative, refuse surgery, and did not follow drug therapy for adequate periods to obtain permanent results.

Your association is to be congratulated for its interest in patient services at the San Francisco Hospital. There have already been startling results in the attempts to better indoctrinate patients at the time of their admission.

Here is an area of services that becomes even more important with the changing situation.

Rehabilitation

Likewise, rehabilitation is a field of patient services that your association has intensified. While we are not yet prepared to say whether drug treatment requires the same careful type of life for the tuberculous patient as was formerly needed, yet the period of home care under drug therapy, and the period of institutional care, call for careful estimation of vocational abilities and needs, and ways of supplying those needs.

Patients in the early stages of tuberculosis now respond so favorably and with such a minimal disruption of their lives that this group tends to require fewer and briefer rehabilitation services than before. On the other hand, tuberculosis is being controlled in a larger proportion of patients who have more serious forms of the disease. It is in this latter group that proper rehabilitation is so important.

Recalcitrant Patients

As I mentioned earlier, the decrease of possibilities of infection makes the potential danger of each spreader of disease more acute. Consequently, the hardened, so-called "recalcitrant" patient, on whom all attempts at achieving cooperation fail, is an increased menace. California now has laws allowing the health officer, at his discretion, to quarantine these patients and if they break quarantine to have them convicted of a misdemeanor and confined for a period of six months. The period is extended to one year for a second offense. California maintains 25 beds in a hospital facility of the Department of Corrections, located at Terminal Island. So far, 125 patients from 32 jurisdictions have been cared for. Of these, two-thirds are now under adequate isolation in their home

communities. This threat of possible enforced isolation no doubt has resulted in hundreds of other patients carefully following isolation orders at home. The effect of the possible misdemeanor conviction on potential recalcitrant patients is far more helpful than the actual application of enforced isolation to the few. Next year, this prison hospital will be moved to a new facility at Vacaville, where more beds will be available to the State than at present.

What of the Future?

There is every reason to believe, unless war or economic crisis destroys our present control measures, that deaths will continue to decline and cases become fewer in number. Indications are, however, that the case rate will not decline as rapidly as the death rate.

Treatment will continue to become more effective, although at the present writing, it is not known how many will relapse in the future with tubercle bacilli that may become resistant to drugs. Hospitalization during the infective stage, with proper public health education, will continue to be essential.

Case-finding techniques should be intensified, especially in specialized areas of high infection rate. This means that more and more we must look to selective case finding, working outward from the known case, or known high prevalence group.

It is becoming even more important than ever that case finding, treatment and rehabilitative services be coordinated. To assure coordination each local tuberculosis control unit should be headed up by a so-called tuberculosis controller, whose prime work should be the effective administration of known control measures. Diffuse control, such as divided responsibilities in the same community, should be avoided. Hospital and public health responsibility is the same. This is now being demonstrated in San Francisco with the new control officer.

Health departments should cooperate in the prolonged administration of drug therapy where otherwise unprovided.

Tuberculosis hospital facilities should be integrated ever closer into the total hospital resources of the community, so that as the need for hospital beds decreases, an orderly

transition can be made to the utilization of these beds for other purposes, particularly for other chronic illnesses.

Despite all the progress that has been made in tuberculosis control, we must be ever watchful. While tuberculosis is rampant in other parts of the world, we cannot expect to be tuberculosis-free here. Nor can we afford to allow our own cases to spread the disease from within. Your association still has a tremendous job to do in tuberculosis control. While continuing to do this job, I am confident you will continue your gradual transition to the broadened interests for which your name provides—Tuberculosis and Health Association.

Your contributions through the years to the health and welfare of the community has amply justified the trust that the public has placed in you.

UC Students Stricken With Food Poisoning After Thanksgiving Dinner

Ninety-seven University of California students became acutely ill after eating a Thanksgiving turkey dinner which had been prepared in the central kitchen of a group of five student cooperative residence halls. Tests made at the State Department of Public Health laboratory of samples of the food eaten by the students showed the presence of *Salmonella* organisms in the turkey, the dressing and the gravy.

About 300 students ate the food in the five residence halls operated by a cooperative association of students, but only 97 were affected. Of the 97, 33 required hospitalization at the university's Cowell Memorial Hospital for from five to six days, 25 were treated by the hospital on an outpatient basis; and 39 were ill but did not require treatment. Symptoms of fever, nausea, vomiting and diarrhea developed in those affected in from 8 to 35 hours after eating the holiday meal.

There was no illness among the students who ate at the hall from whose central kitchen meals are prepared for the other four houses in the student-run cooperative. At another of the houses, only one became ill and at a third only four were affected, but

NOTICE OF HEARING

The State Board of Public Health will hold a public hearing on January 7, 1955, at 10.30 a.m., in Room 709, State Building, 217 W. First St., Los Angeles, on the proposed amendment of Section 2564, Article 3, Subchapter 1, Chapter 4, of Title 17, California Administrative Code, pursuant to the authority of Section 208 of the Health and Safety Code.

The change is proposed because the present definition of diarrhea of the newborn does not include all illnesses generally considered to fall into that classification.

Copies of the proposed regulations are available for inspection in the California State Department of Public Health, Los Angeles and San Francisco offices, and are made a part of this notice by reference.

MALCOLM H. MERRILL, M.D.
Executive Officer
State Board of Public Health

of the remaining two houses of the group over three-fourths were stricken in one, and in the other almost 60 percent.

As soon as cases began to come in to the university's hospital on the day after Thanksgiving, an investigation was launched by the university with the cooperation of the Berkeley Health Department and the State Department of Public Health. Tests completed by the State Health Department's bacteriology laboratory showed *Salmonella* to be present in the food samples, but intensive investigation is being conducted to determine at what stage in the food handling the infection took place.

Registration Exam for Sanitarians

An examination for registration as a sanitarian in California will be held February 16th in Berkeley and Los Angeles. Final date for filing is February 2d. Candidates wishing to take this exam to qualify for a registered sanitarian certificate may obtain further information from the Bureau of Sanitary Engineering, State Department of Public Health, 2180 Milvia Street, Berkeley 4.

Public Health Positions

Long Beach

Public Health Nurses: The Long Beach Department of Public Health has two vacancies. Salary range, \$343-\$417. For a generalized program, school nursing not included. Car furnished. Department serves population of 277,000. Nursing staff includes a director, one supervising nurse, 5 clinic nurses and 12 staff nurses.

For further information write I. D. Litwack, M.D., Health Officer, Long Beach Department of Public Health, 2655 Pine Avenue, Long Beach.

City of Pasadena

Sanitarian: Opening for registered sanitarian. Salary range, \$344-\$419. Pasadena residence is not required. Apply to Personnel Department, City Hall, Pasadena.

San Diego

Public Health Veterinarian: Salary range \$438-\$532. California license required before appointment. Requires master's degree in public health in addition to three years of experience in licensed practice of veterinary medicine, of which at least one year must have been in a recognized public health setting. Applications on official forms desired by January 12, 1955. Write County Civil Service, Civic Center, San Diego.

Public Health Nurses: Salary \$327-\$397. Applicants must possess a California Public Health Nursing Certificate. Duties include general public health nursing, including school health service.

Write J. B. Askew, M.D., Director, Department of Public Health, Room 044, Civic Center, San Diego.

Personal Notes

DR. EDWARD KUPKA, on two years' leave of absence from the Bureau of Tuberculosis, California State Department of Public Health, at last report was deeply engaged in the monumental task of seeing to the medical and health needs of evacuees from the areas of Viet-Nam recently taken over by the Reds.

DR. BELLE DALE POOLE, Child Health Consultant in the California State Department of Public Health, Los Angeles office, has returned after a year as professor of maternal and child health with the Department of Preventive Medicine and Public Health of the American University, Beirut, Lebanon.

MISS MARIAN DAVIS, Supervising Occupational Therapist, has returned to the department after spending six weeks in Japan under auspices of the World Health Organization.

MRS. MATHILDE BERRETTINI, Occupational Therapist assigned by the department to San Leandro, has resigned to accept a Fulbright Commission Grant to work in a new cerebral palsy unit in Rome.

MRS. BEVERLY CARROLL, Occupational Therapist assigned to Fresno, has resigned to accept an overseas appointment with Special Services and will be either in France or Germany.

DIPHTHERIA — A CONTINUING PROBLEM

Diphtheria has declined markedly in California. However, cases do still occur, singly and in groups.

With this decline there has been a shift in age distribution from early childhood to adolescence and early adulthood.

The principle control measure is diphtheria immunization. Continued vigilance is needed to see that children receive adequate immunization. With the shifting age distribution of diphtheria, greater attention also needs to be given to the problem in older children and adults.

Six recent cases of diphtheria, with one death, in Sacramento County, again focuses attention on the importance of diphtheria booster shots in keeping high the community level of immunization. While all cases showed a history of having been immunized against diphtheria, only one had received a booster injection. For the others, the interval since receiving primary injections ranged from three to nine years.

(Three more cases and a second death have been reported from Sacramento County. As of December 7th, the investigation had not shown any direct association with the first outbreak.)

The trend of diphtheria toward becoming a disease of adolescence and early adulthood is borne out in statistics compiled by the State Department of Public Health over a period of the past 30 years. In the five-year period 1925-29 only 25 percent of cases occurred after 15 years of age. In the period 1950-54 cases occurring after the age 15 have been 62 percent of the total. This trend shows even more plainly in the diphtheria deaths, as noted in the accompanying graphs and tables. In 1925-29 approximately 80 percent of the diphtheria deaths occurred in children under 9, and only 12 percent in the age brackets above 15. Contrasted with this, in the 1950-54 period, only 30 percent of the deaths were occurring in children under 9, as compared with 67 percent over 15.

Cases of diphtheria have dropped dramatically in the past 25 years, and largely through childhood immunization. In the five-year period 1925-29, nearly 26,000 cases were reported in California, with 1,347 deaths. In the period 1950-1954 (through November

27th, 1954) there were only 623 cases reported, with 76 deaths.

The Sacramento outbreak occurred in the Del Paso Heights residential area of North Sacramento. Four of the cases, and the deaths, were in one family. The fifth case, a 14-year-old boy, lived three houses away in the same block, and had served as baby sitter in the first household. The sixth case lived several blocks away, but no direct association could be established. Ages ranged from 3 to 16 years.

Laboratory tests on three of the cases showed the outbreak to be due

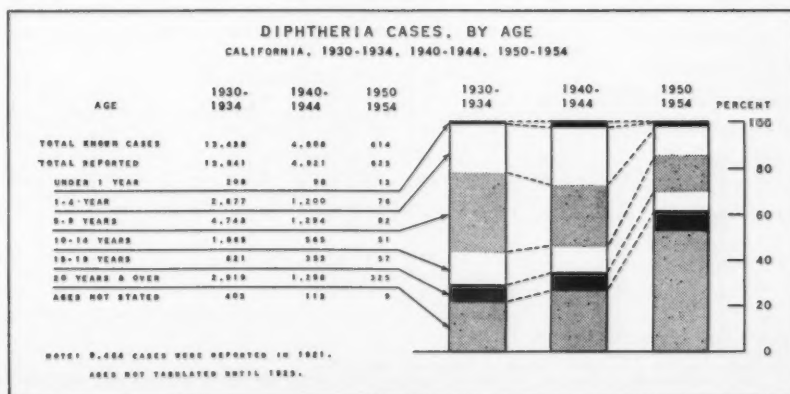
TABLE 1
CASES AND DEATHS—DIPHTHERIA—PERCENTAGE* DISTRIBUTION BY AGE GROUPS

Cases	1925-1929		1930-1934		1940-1944		1950-1954*	
	Cases	Percent	Cases	Percent	Cases	Percent	Cases	Percent
Under 1 year.....	450	1.8	208	1.6	98	2.0	13	2.1
1- 4 years.....	5,276	21.2	2,877	21.4	1,200	24.9	76	12.4
5- 9 years.....	9,061	36.3	4,748	35.3	1,294	27.0	92	15.0
10-14 years.....	3,517	14.1	1,865	13.9	565	11.8	51	8.3
15-19 years.....	1,444	5.8	821	6.1	353	7.3	57	9.3
20 and over.....	5,183	20.8	2,919	21.7	1,298	27.0	325	52.9
Totals.....	24,931	100.0	13,438	100.0	4,808	100.0	614	100.0
Not stated.....	958	---	403	---	113	---	9	---
Total reported.....	25,889	---	13,841	---	4,921	---	623	---
Deaths								
Under 1 year.....	61	4.5	53	6.5	22	5.4	1	1.3
1- 4 years.....	578	43.0	349	43.0	141	34.8	13	17.1
5- 9 years.....	435	32.3	235	28.9	102	25.2	9	11.8
10-14 years.....	116	8.6	55	6.8	17	4.2	2	2.6
15-19 years.....	30	2.2	13	1.6	4	1.0	---	---
20 and over.....	127	9.4	107	13.2	119	29.4	51	67.1
Totals.....	1,347	100.0	812	100.0	405	100.0	76	99.9

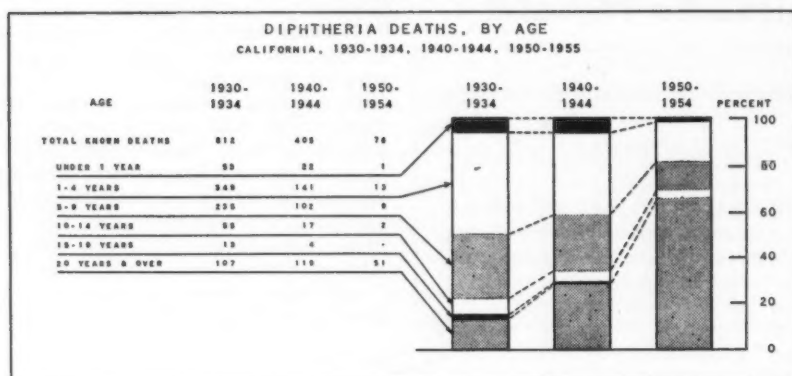
* Percentages based upon known ages.

* Cases to November 27, 1954, deaths to October, 1954.

GRAPH 1



GRAPH 2



to the *gravis* strain, most virulent of diphtheria strains. No specific source for the cases was found. The State Department of Public Health assisted in the investigation at the request of the Sacramento County Health Department.

The low level of community immunization was noted in a school and community survey conducted since

the outbreak in the Del Paso Heights area. Less than 50 percent of the kindergarten through second grade students who were checked in the Del Paso elementary school in October gave a history of adequate immunization, and this percentage fell to 34 among 5-15 year olds in the Del Paso neighborhood. The summary of immunization status is given in the following table:

TABLE 2
SUMMARY OF DIPHTHERIA IMMUNIZATION STATUS IN SELECTED GROUPS
SACRAMENTO COUNTY, CALIFORNIA

October, 1954

Group	Age	Total persons	History of immunization*		Adequate immunization†		No immunization		Unknown	
			No.	%	No.	%	No.	%	No.	%
Del Paso Elementary										
Kindergarten, a.m.	5 yr.	32	18	56.3	16	50.0	6	18.7	8	25.0
Kindergarten, p.m.	5 yr.	25	17	68.0	17	68.0	5	20.0	3	12.0
1st grade	6 yr.	32	18	56.3	15	46.8	6	18.7	8	25.0
2d grade	7 yr.	36	19	52.7	11	30.6	7	19.5	10	27.8
Subtotal		125	72	57.6	59	47.2	24	19.2	29	23.2
Neighborhood groups										
Group 1A	5 yr.	11	7	63.6	6	54.5	2	18.2	2	18.2
Group 2A	5 yr.	11	8	72.7	4	36.3	3	27.2		
Total under 5		22	15	68.2	10	45.4	5	22.7	2	9.1
Group 1B	5-15	7	6	85.7	4	66.6			1	
Group 2B	5-15	28	25	89.2	8	28.5	3	10.7		
Total 5-15		35	31	88.5	12	34.3	3	8.6	1	2.9
Neighborhood groups totals		57	46	80.7	22	38.5	8	14.1	3	5.2
Grand totals		182	118	64.8	81	44.7	32	17.6	32	17.6

Group 1—Persons living near Cases 1-5.

Group 2—Persons living near Case 6.

* Defined as completion of a series of diphtheria inoculation at any time.

† Defined as having completed a series of diphtheria inoculation and having had boosters every five years and within the last five years.

As a result of the outbreak and the low level of immunization as revealed in the survey, immunizations have been offered to school children under 10 years of age through cooperative efforts of physicians, the school authorities and the county health department. Educational efforts emphasizing the need for adequate immunization have been intensified in the affected neighborhood.

Swine Disease Brings Public Health Protection to Californians

For years public health authorities have strongly recommended cooking of raw garbage before feeding it to hogs as a measure of protection against the transmission of trichinosis to humans. Little headway was made in California until an epizootic of vesicular exanthema spread from California to other states in 1952 and threatened the hog-raising industry. As an indirect result Californians will be in less danger of trichinosis.

Drastic control measures had to be taken to save the industry and remove the threat of vesicular exanthema to the hog industry of other states as well. Since the highly contagious disease (which is not transmitted to humans) is spread by the feeding of raw garbage, strict quarantine measures were instituted by the State and Federal Departments of Agriculture. All counties of the State were placed under state and federal quarantine, and the quarantine was lifted as the feeding of raw garbage to hogs was discontinued.

To be released from quarantine, hog ranches had to install approved garbage cookers or change to grain feeding. Twenty-nine counties in California are now entirely free of quarantined ranches. All of the State's counties have now been released from general federal quarantine and only individual premises on which raw garbage has been fed to swine within 30 days remain under quarantine. One hundred fifty-two individual premises are still under quarantine until they comply with the regulations.

Veterinarians of the State Department of Agriculture are carrying out the control program.

Health Center Construction in California, 1946 to Date

Since 1946, 35 new health centers have been completed in California and 10 others are currently under construction or are in the planning stage. Of the total of 45 health centers completed, under construction, or in the planning stage, 17 have received financial assistance from Hill-Burton and State matching funds.

The 45 health centers include facilities ranging in size from the recently occupied nine-story headquarters building of the Los Angeles City Health Department, with its 151,120 square feet of floor space, to a sub-center for the Riverside County Health Department, with only 1,250 square feet of floor space.

Thirty-eight of the new facilities are classed as primary health centers, housing administrative personnel and other health department staff; seven are classed as secondary health centers, housing area field staff only.

All of the 17 projects receiving federal and state assistance are primary health centers, with 11 now completed and six either under construction or in the planning stage. Together they represent an investment in Hill-Burton funds of \$1,419,783.59, plus the same amount in state funds and at least that amount in local funds. Cost figures on the 28 projects financed without Hill-Burton and state matching funds are not readily available.

The 17 centers assisted with state and federal funds produced 189,301 square feet of space. The 28 centers constructed with local funds produced 477,338 square feet of area.

The State Department of Public Health, upon recommendation of the State Advisory Hospital Council, allocates the limited federal funds provided to California each year on the basis of carefully established priorities for both hospital and health center construction. Each year the hospital and health center construction program is able to assist only a small percentage of the applicants for assistance, all other applications being deferred for consideration in a subsequent year. In some instances communities and local health jurisdictions have been able to finance hospital and health center expansion exclusively with local funds and have gone ahead with their building programs.

A detailed listing of the health centers constructed with and without state and federal assistance is below.

Space standards to provide public health services in jurisdictions of various population sizes has been deter-

mined with the valued assistance of the California Conference of Local Health Officers. Prior to the current fiscal year, priority was determined on the basis of acceptable primary and secondary space, size of popula-

Health Center Facilities Constructed Since 1946 With Hill-Burton Assistance

Health Jurisdiction	Location	Completed—Now in Operation	
			Square feet constructed primary center
Alameda County	San Leandro		25,820
Butte County	Oroville		2,685
Fresno County	Fresno		20,550
Inyo County	Independence		2,510
Kings County	Hanford		5,518
Los Angeles City	Westchester		4,656
Madera County	Madera		6,250
Marin County	San Rafael		5,480
San Benito County	Hollister		2,647
Santa Clara County	San Jose		20,555
San Luis Obispo County	San Luis Obispo		6,430

Health Jurisdiction	Location	Under Construction or in Planning Stage	
			Square feet constructed primary center
Berkeley City	Berkeley		8,000
Contra Costa County	Martinez		15,000
Kern County	Bakersfield		19,700
Los Angeles City	Southwest District		15,000
Sacramento County	Sacramento		16,600
San Jose City	San Jose		11,200
Total square footage			189,301

Health Center Facilities Constructed Since 1946 Without Hill-Burton Assistance

Health Jurisdiction	Location	Completed—Now in Operation	
		Primary	Secondary
Long Beach City	Long Beach	44,000	
Los Angeles City	Southeast District	26,000	
Los Angeles City	Wilmington	8,200	
Los Angeles City	Pacoima	4,000	
Los Angeles City	Hollywood	22,400	
Los Angeles City	Canoga Park	4,000	
Los Angeles City	San Pedro	13,400	
Los Angeles City	Watts	6,510	
Los Angeles City	North Hollywood	6,510	
Los Angeles City	Los Angeles-Central	151,120	
Los Angeles County	Bellflower	9,206	
Los Angeles County	San Antonio District	13,253	
Los Angeles County	Burbank		5,498
Los Angeles County	Willowbrook		2,853
Los Angeles County	Central-Los Angeles	45,023	
Monterey County	Salinas	4,759	
Napa County	Napa	3,600	
Placer County	Auburn	3,075	
Riverside County	Palm Springs		1,250
San Bernardino County	San Bernardino	12,000	
San Francisco City-County	Sunset District		4,500
San Mateo County	Redwood City	17,920	
Santa Barbara County	Santa Maria		3,500
Tulare County	Tulare		2,004

Health Jurisdiction	Location	Under Construction or in Planning Stage	
		Primary	Secondary
Los Angeles City	East District	13,500	
Los Angeles County	Monrovia	7,652	
Los Angeles County	Firestone District		2,625
Orange County	Santa Ana	38,980	
Total square footage			477,338

Recapitulation

		Square feet
A. Constructed with Hill-Burton Assistance		
1. Now in operation		103,101
2. Under construction or in planning stage		86,300
B. Constructed Without Hill-Burton Assistance		
1. Now in operation		414,581
2. Under construction or in planning stage		62,757
Total square footage		666,639

HEALTH CENTER NEEDS IN ORDER OF PRIORITY WITH INVENTORY OF EXISTING ACCEPTABLE SPACE, 1954-55

Health jurisdiction	Population 7-1-53	Existing acceptable primary space	Additional primary -space needed	Percent need met	Priority group
Contra Costa County	340,200	---	33,320	0	A*
El Dorado County	16,400	---	2,600	0	A
Kern County	263,500	---	26,100	0	A*
Los Angeles City-Central District	250,000	---	26,000	0	A
Los Angeles City-Northeast District	245,700	---	24,600	0	A
Los Angeles City-San Fernando District	467,600	---	45,800	0	A
Los Angeles City-Southwest District	234,900	---	23,500	0	A*
Los Angeles City-West Los Angeles District	206,800	---	21,100	0	A
Mariposa County	4,800	---	2,600	0	A
Mendocino County	49,200	---	6,300	0	A
Modesto City	19,300	---	2,600	0	A
Orange County	280,900	---	27,500	0	A
Plumas County	13,000	---	2,600	0	A
San Jose City	103,200	---	11,200	0	A*
Santa Barbara County	59,000	---	7,400	0	A
Tulare County	144,200	---	15,300	0	A
San Bernardino City	76,600	1,254	7,946	14	B
Humboldt-Del Norte Counties	98,600	1,618	9,182	15	B
Los Angeles County-Whittier District	133,856	2,206	12,094	15	B
Los Angeles County-Monrovia District	150,854	2,566	13,234	16	B
San Diego County	711,400	11,076	58,624	16	B
Oakland City	397,900	6,580	32,420	17	B
Santa Cruz County	65,600	1,360	6,740	17	B
Yolo County	48,600	1,045	5,155	17	B
Ventura County	133,100	3,000	11,200	21	B
Riverside County	211,900	4,720	16,680	22	B
Los Angeles County-Inglewood District	163,602	3,827	13,173	23	C
Sonoma County	115,800	2,896	9,604	23	C
Merced County	73,700	2,429	6,471	27	C
Monterey County	174,200	4,759	13,141	27	C
Los Angeles City-Venice-Westchester District	150,900	4,674	11,126	30	C
Alameda City	66,600	2,613	5,687	31	C
Santa Barbara City	49,200	2,000	4,300	32	C
Butte County	65,500	2,685	5,415	33	C
Sacramento County	155,000	5,555	10,745	34	C
Sutter-Yuba Counties	60,500	2,803	4,797	37	C
Colusa County	11,500	1,000	1,600	38	D
Pasadena City	110,000	4,989	7,011	42	D
San Joaquin Local Health District	224,500	10,000	12,700	44	D
San Bernardino County	245,300	12,000	12,500	49	D
Marin County	107,500	5,840	5,860	50	D
Los Angeles City-Watts District	118,500	6,510	6,290	51	D
Placer County	47,300	3,075	2,925	51	D
Stanislaus County	122,400	6,792	6,408	51	D
Napa County	53,500	3,600	3,200	53	D
San Francisco City & County	783,700	43,183	33,617	56	D
Los Angeles County-Glendale District	178,475	13,515	8,585	61	E
Los Angeles County-Compton District	218,844	11,241	6,959	62	E
Los Angeles County-Bellflower District	163,602	10,835	6,165	64	E
San Mateo County	279,200	17,920	9,480	65	E
San Luis Obispo County	78,100	6,430	2,870	69	E
Solano County	124,800	9,355	4,145	69	E
Los Angeles County-Torrance District	176,350	12,951	5,049	72	E
Fresno County	287,600	20,550	7,650	73	E
Imperial County	65,500	6,026	2,074	74	E
Los Angeles County-San Antonio District	242,216	18,074	6,126	75	E
Berkeley City	117,700	10,000	2,700	79	F
Los Angeles County-Pomona District	131,731	11,164	2,936	79	F
Los Angeles County-Alhambra District	254,964	21,103	4,397	83	F
Santa Clara County	244,700	20,555	3,945	84	F
Los Angeles City-Hollywood-Wilshire District	260,800	22,400	3,400	87	F
Kings County	49,000	5,518	782	88	F
Sacramento County	181,700	16,600	1,900	90	F
Alameda County	214,600	20,294	1,406	94	F
Los Angeles County-Santa Monica District	135,981	13,778	622	96	F
Inyo County	11,800	2,635	---	100	F
Long Beach City	283,900	33,000	---	100	F
Los Angeles City-San Pedro District	103,400	14,900	---	100	F
Los Angeles City-Southeast District	116,400	26,266	---	100	F
Los Angeles County-East Los Angeles District	127,482	16,295	---	100	F
Los Angeles County-San Fernando District	46,743	6,859	---	100	F
Madera County	39,900	6,250	---	100	F
San Benito County	13,200	3,094	---	100	F

* Funds have been allocated to these health jurisdictions this year.

printed in CALIFORNIA STATE PRINTING OFFICE

tion and adjacent services. In the 1954-55 State Plan, priority is based upon the percent of need met by acceptable primary health center space.

The opposite table, taken from the 1954-55 State Plan, shows the priority status of health jurisdictions in California indicating the existing acceptable primary space and the additional space needed. Four of the health jurisdictions included in Priority Group A have received allocations this year.

GOODWIN J. KNIGHT, Governor

MALCOLM H. MERRILL, M.D., M.P.H.
State Director of Public Health

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Entered as second-class matter Jan. 25, 1949,
at the Post Office at San Francisco, California,
under the Act of Aug. 24, 1912. Acceptance
for mailing at the special rate approved for
in Section 1103, Act of Oct. 3, 1917.

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